State of Vermont
Department of Vermont Health Access
Vermont Blueprint for Health
312 Hurricane Lane, Suite 201
Williston VT 05495-2807
dvha.vermont.gov

Agency of Human Services

[Phone] 802-879-5988
[Fax] 802-879-5651

Blueprint Expansion Design and Evaluation Committee
Minutes of February 14, 2012

Attendees:

C. Jones	Blueprint	L. Dulsky Watkins	Blueprint
L. Hubbell	CVMC	L. McLaren	MVP
M. Hartman	APS	L. Ruggles	St. Johnsbury
J. Samuelson	Blueprint	P. Harrington	Vt. Medical Society
K. Browne	DVHA	P. Jones	Blueprint
B. Tanzman	Blueprint	R. Wheeler	BCBSVT
P. Biron	BCBSVT	M. Phillips	UVM
B. Steckel	FAHC	S. Fine	Danville Health Center
J. Shaw	UVM	B. Tanzman	Blueprint
J. Flynn Weiss	MVP	S. Frey	BCBSVT
S. Narkewicz	Rutland	P. Launer	Bi-State Primary Care
L. Francis	Gifford	D. Noble	Bennington
C. Fulton	VPQHC	A. Garland	BCBSVT

I. *General Update*:
   a. 2011 Blueprint Annual Report has now been released and is available on the Blueprint and Health Care Reform websites.

II. *Presentation of H.559 Section 28 (Blueprint in 2012 Health Reform Bill)*:
   a. There has been a push to reconsider the timing of when CHT start-up payments should begin. Should payments begin as soon as a practice begins preparation for Blueprint recognition or after the practice has received NCQA scoring?

   b. The 2011 NCQA scoring standards require more prep work and are more rigorous and demanding, especially related to population management.

   c. The national trend is to provide CHT support to committed practices at the front end (prior to scoring).

d. Here in Vermont we believe that having the CHT's on board 6 months prior to actual scoring would be a tremendous help to practices. The Community Health Teams could actively begin outreach, health education, care coordination, etc. for those practices preparing for scoring. Active panel management, support of social workers and counselors would be especially helpful prior to scoring.

e. A draft timeline of the estimated number of practices scheduled to be scored was distributed.

f. Beth Steckel stated that the IT work should also begin in advance of scoring. DocSite interfaces need to be completed sooner rather than later in the prep process. Dr. Jones responded that EMRs are getting better at supporting some forms of reporting. We have also begun an intensive focus of IT connectivity issues during the first quarter of 2012.

g. *Panel Management*: Beth Steckel stated that Fletcher Allen would need to have clear documentation if CHT members are to function as panel managers. Dr. Jones questioned whether it was wise to be so specifically prescriptive. Panel management is a core responsibility which is being handled differently at each health service area. (Example: In Bennington the panel management is a shared responsibility.) Panel management must be in place prior to scoring.

h. Dr. Wheeler stated that the insurers are looking for accountability and metrics to show what the Blueprint program can really deliver. We need to be able to evaluate the impact of the Blueprint program. We need something that will be convincing to the market. Although the NCQA scoring is a good threshold, employers are asking for more detailed activity counts. Activity reporting should be tied to the source of funding. Dr. Wheeler requested that an effort be focused on pushing the tracking / reporting function and finding commonality to show that value is being delivered to all. We need to know that the program is comprehensive and that that people are not falling through the cracks. As of July, 2013, BCBSVT would like to discontinue their chronic disease program and would need to be able to support that change with data.

   Dr. Jones reported that a cultural evolution is still in progress regarding shared reporting. We have one organization that has been unwilling to share their data. The HSAs are all at various levels when it comes to reporting. Dr. Watkins noted that we do have an activity tracking planner but there is not a communication system that tracks that data across EMRs and across different systems. The activity tracking planner is currently being tested.

   Lou McLaren stated that MVP would expect that all CHTs would share their tracking information. Uniform expectations need to be set. MVP would be reluctant to front load CHT payments without evidence of results. MVP would be willing to shift money to the PPPM's from the CHT payments.

Dana Noble stated that she has no control over how PMPM money is spent. CHT payments would be preferable. Andrew Garland suggested that for clarification we revisit our original design and roles of the CHT as well as the role of the PPPM funding.

Dr. Jones offered to better familiarize the payers about the CHTs. It would benefit the insurers to know what each CHT member was doing in their community. The Blueprint team will pull together white papers for each CHT member to include each member's role, where the employee is housed, what the employee is doing in each community, etc.

With no further time, the meeting was adjourned at 10:15 a.m.